DELAWARE HEALTH AND SOCIAL SERVICES

Division of Public Health

DELAWARE
EMERGENCY MEDICAL SERVICES FOR CHILDREN

Consent for Enrollment in the Special Needs Alert Program (SNAP-911)

The Delaware Emergency Medical Services for Children program for Children with Special Healthcare/Medical Needs will keep all information provided on the Emergency Information Form and the Home Visit Form confidential, pursuant to the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, and effective Nationwide as of April 14, 2003.

Each Ambulance Service throughout the State of Delaware is required to present you with a Notice of their operation's Privacy Practices, as well as explain to you your rights under the Federal HIPAA laws and guidelines when visiting your home to obtain the above-referenced information for this program. In addition, all emergency medical personnel involved in responding to a medical emergency regarding your child are required to follow all privacy practices and stipulations in place, and cannot discuss, or disseminate in any form, any Protected Health Information (PHI) regarding your child, unless it is imperative to administering care required within the scope of their medical duties where your child is concerned.

By signing below, you acknowledge understanding that the information provided on the attached Enrollment Form may be shared with emergency medical field responders to aid them in providing the necessary emergency medical care to your child and that you have received a copy of the local EMS agency privacy practices.

As a result of the form being used to provide a more complete medical record for your child, there is a potential for this protected health information to be redisclosed to other non-HIPAA covered entities.

Failure to sign this form will not ever result in denial of normal processing of emergency calls or denial of any medically necessary emergency treatment. Please feel free to contact the Ambulance Service at _____, the County EMS Agency at _____or the Emergency Medical Services for Children program in the Division of Public Health 302-223-1355 for any questions about the consent form or the SNAP-911.

By signing below, I give permission to share the Enrollment Form with necessary emergency medical staff so that they may provide all necessary emergency medical care to my child. I also acknowledge that I have received a copy of this completed consent form and local EMS agency privacy practices. I understand that I may revoke this statement in writing at any time, except to the extent that the organization named above has already taken action on this authorization. To revoke this statement notify in writing your local county EMS agency stating that you wish to withdraw your child from the "Special Needs Alert Program." Include your correspondence to the county EMS agency: the name of the child, the date of birth and the address.

_____	_____	_____
Parent/Guardian (Print Name) or Legal Custodian	Parent/Guardian (Signature) or Legal Custodian	Date

_____
Relationship to the child

_____	_____	_____
Witness (Print Name)	Witness (Signature)	Date

This Consent for Enrollment is effective for one year from the date of signature. A new consent and updated health forms will be required to continue in the Special Needs Alert Program after one year.

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